EXHIBIT C

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A Better Reference for Pricing

Avoiding the Pitfalls of Charge- and Medicare-Based Methodologies When Pricing Non-Contracted Claims

A White Paper Developed by MultiPlan.
August 2019

Introduction

With healthcare expected to reach 20 percent of our national GDP by 2025, the national dialogue is increasingly focused on medical costs[1]. All parties in the healthcare debate are scrutinizing ways to eliminate long-term disparities, particularly between actual treatment costs and the prices charged for care.

One such relatively new strategy is reference-based (or reference) pricing, a mechanism for establishing defined-contribution benefit plans. Typically used with HRAs and HSAs – and more recently with private exchanges – reference-based pricing gives plan members a fixed amount of coverage for a specific service, and a means of selecting providers based on their charges relative to that fixed contribution. A selection below the reference point eliminates out-of-pocket costs for the member. The reference point is set based on analysis of typical reimbursement and other factors including the plan's goals for savings versus member choice.

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Reference-based pricing enables lower costs to the plan and member, a more educated and engaged healthcare consumer, and a provider compelled to contract at prices near the reference point. So why have only 13 percent of large employers[2] adopted the strategy? There are challenges to implementation, which include somewhat narrow applicability (to elective, standardized services with high price variability), its impact on a plan member's access to quality providers (garnering regulatory attention), and resources needed to establish a suitable reference point.

While the concept of prospective reference-based pricing is still struggling to gain traction, use of a reference point for retrospective, out-of-network reimbursement is not a new idea. Traditionally, health plans have used a conservative methodology, such as a percentile of usual and customary (U&C) charges, to determine the reference, and that methodology is reflected in their plan documents. In the absence of a reimbursement agreement, providers generally have the right to bill members for the difference between this reference amount or "benefit limit" and the charges billed.

However, many plans have shifted away from U&C in their out-of-network strategy. Now, Medicare is commonly used as the basis for the reference point, and is typically what "reference-based pricing" refers to in this context. Proponents argue that Medicare is a well-established and understood methodology with inflation-fighting mechanisms. Benefit plan documents may be modified to reflect the Medicare-based methodology, or reference-based pricing may work as a cost management strategy for some or all of the plan's out-of-network claims.

[1] Advisory Board Daily Briefing, February 16, 2017

[2] "Some Good News About Reference-Based Pricing", Mercer, August 12, 2016

Pitfalls of Medicare-Based References

While a Medicare-based methodology does offer an inflation buffer that a U&C methodology such as FAIR Health cannot, there are several pitfalls.

Relevancy - Medicare is not available to the general population. Only the Medicare-using population and certain procedures specifically allowed under the plan are taken into consideration when calculating the rates. If Medicare does not pay for a particular procedure, pricing services must use a proxy amount such as billed charges to compensate, diluting the benefits of Medicare as a well-understood and accepted reference.

Relevancy, Clarity and Effectiveness

Clarity - A Medicare-based reference point is inherently misleading. The average consumer does not understand just how low Medicare rates are. On its surface, a policy to reimburse at a level well above what Medicare pays sounds fair, maybe even generous when compared to the traditional methodology which reimburses at a percentage below U&C. However, when a provider anticipating low reimbursements from payers increases the charges to compensate, the gap between an elevated charge and the bare-bones Medicare reimbursement can be significant, as shown in Table 1.

Table 1: Medicare vs. U&C – Member Impact

	80th Percentile of U&C	120% of Medicare
$5,000 Bill Reduced To	$2,582.90	$748.50
Plan Pays 60%	$1,549.74	$449.10
Member Pays 40%	$1,033.16	$299.40
Provider Balance Bills	$2,417.10	$4,251.50
Total Member Obligation	$3,450.26	$4,550.90

Effectiveness - The use of Medicare as the basis for calculating out-of-network reimbursement creates a flawed equation from inception. While cost data from hospitals is used to estimate allowable amounts, there is no guarantee the resulting allowed amounts will cover a provider's costs. And, when combined with other governmental pressures such as budget neutrality, sequestration, and SGR an inherent bias toward lower reimbursement under Medicare is inevitable. Providers compensate for unprofitable or, at the least unpredictable, Medicare reimbursements by significantly increasing their commercial charges.

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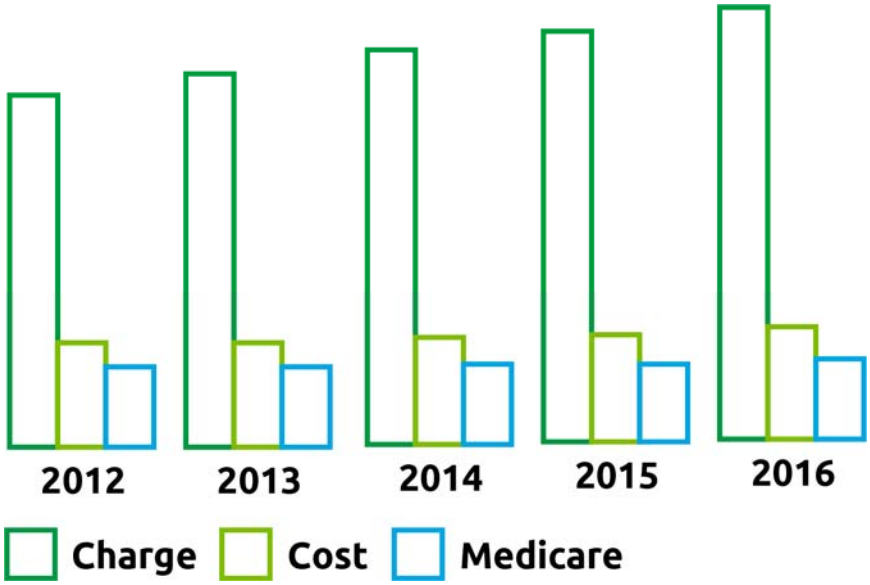
A MultiPlan study using CMS Medpar data illustrates the point. From 2012 to 2016, the average charge across all DRGs nationally has increased by 26%. Average cost has risen by 15%, and Medicare by 6%. In 2012 Medicare reimbursement fell short of the average cost by 21% and in 2016 that shortfall was 26%.

Figure 1: Medicare vs. Cost Trend



A More Effective Methodology

MultiPlan's Data iSight service avoids the pitfalls of Medicare– as well as the obvious drawbacks of a charges-based U&C approach – as a reference point for repricing non-contracted claims. Instead of these flawed approaches, Data iSight uses a patented methodology that is defensible, repeatable and transparent.

Facility Pricing - Comprehensive facility cost data is publicly-available, and can serve as the foundation of a reimbursement calculation any reasonable provider would find to be both relevant and fair. MultiPlan's Data iSight service goes even further to base reimbursement not on the facility's actual cost, but on the costs of a comparison group of similarly sized and located facilities performing the same procedures at the same severity levels. This removes from the debate any objections from the provider on the basis of its location, size, type (e.g., teaching hospitals), and service complexity. The methodology ensures a reimbursement level at which at least 90% of the claims in the comparison group would be profitable. It also serves to reward providers that are more cost efficient than their peers.

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Professional Pricing - For professional claims where actual costs aren't readily available, Data iSight determines a fair price using amounts generally accepted by providers as payment in full for services. Claims are first edited, and then priced using widely-recognized:

- AMA-created Relative Value Units (RVU), to take the value and work effort into account
- CMS Geographic Practice Cost Index (GPCI), to adjust for regional differences

Data iSight multiplies the geographically-adjusted RVU for each procedure by a median based conversion factor to determine the reimbursement amount. This factor is specific to the service provided and derived from a publicly-available database of paid claims.

Results

Table 2 summarizes Data iSight's performance, reflecting the 1.4 million claims and $3 billion in charges priced in 2016 with a Data iSight reduction.

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Table 2: 2016 Performance

Type	Savings	Acceptance
Inpatient	53%	99.4%
Outpatient	75%	98.7%
Professional	69%	94.5%

These savings reflect a variety of configuration options selected by the plans to reflect their preferred balance of savings and member satisfaction. Data iSight offers a number of options, such as guardrails that ensure a reimbursement never strays below or above a benchmark such as Medicare or the plan's benefit limit, if different than the reference point.

Defending the Reference

Medicare-based reference pricing effectively shifts costs from payer to patient. Unlike network contracted providers or those that have negotiated a claim settlement, providers paid a fraction of their charges by the payer's use of Medicare – or any analytics-based repricing methodology for that matter – are generally free to bill the patient for the remaining amount. In effect, particularly when the Medicare reference point is low, the payer shifts the majority of the costs incurred out-of-network to the patient.

While most health plans would agree it's reasonable to ask patients to pay more when they fail to take advantage of the network, there are degrees of fairness for the patient as well as for the provider, and most find their reference-based pricing program requires some form of support to mitigate the claim adjustments and/or member balance billing that results when providers object.

Data iSight preempts conflicts over reimbursement and balance billing. Because of its cost- and reimbursement-based methodologies, Data iSight is an inherently fair reference point for providers. The service also incorporates a number of features that further support the fairness of the program.

Data iSight reimbursement calculations are available online to the provider, payer and member.

Transparency – The Data iSight reimbursement, and how it was calculated, is available to the provider, payer and member via a secured web portal. In addition to the Data iSight reimbursement amount, the analysis includes comparisons to both Medicare and to the peer group used to determine the Data iSight price.

Provider Inquiry Management – In addition to publishing the portal link, clients typically choose to direct provider inquiries to MultiPlan, where a Data iSight expert can explain the methodology in detail, answer questions, discuss ramifications of appealing the claim (including regulatory prohibitions on balance billing), and if allowed, negotiate a settlement.

Patient Advocacy Program – Data iSight offers an optional Patient Advocacy program to support plan members if and when a provider bills them for the difference between their charges and the Data iSight reimbursement. The program leverages the health plan's brand to promote the value-added service to the member. Data iSight staff proactively work with the provider to settle the claim, eliminate the bill, and improve plan member satisfaction.

Conclusion

Reference-based pricing used retrospectively can deliver significant savings to health plans and members when services are incurred without a reimbursement agreement. Beyond the methodology itself, retrospective reference-based pricing works best when there are services available to support both providers and members.

Recently, use of Medicare to establish the out-of-network reference point has grown in popularity, but it presents significant pitfalls that limit not only its effectiveness for the plan, but also its acceptance by providers.

Even health plans with an aggressive stance on out-of-network utilization find that the reference point must be defensible and fair to providers in order to be effective for members. Without defensible, fair pricing like Data iSight, plans will experience increased friction with providers and plan members.

About MultiPlan

MultiPlan is committed to helping healthcare payers manage the cost of care, improve their competitiveness and inspire positive change. Leveraging sophisticated technology, data analytics and a team rich with industry experience, the company interprets clients' needs and customizes innovative solutions that combine its payment integrity, network-based and analytics-based services. MultiPlan is a trusted partner to over 1.4 million healthcare providers nationwide and to 700 healthcare payers in the commercial health, dental, property and casualty, and government markets with 50-75 million members using our networks. MultiPlan is owned by Hellman & Friedman and other investors.

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